Five Important Health Care Trends that Consumers Should Track

written by Theresa Hush | July 29, 2021

In the world of health care, change is never-ending. Politics, government regulation, scientific advancement, technology, and the economics and financing of health care foster shifts to reshape how care is delivered and how much it costs. Many of these shifts are completely invisible to us as health care consumers. But they also drive what is happening to and around us, determining availability and affordability of physicians or other services.

This came home to me last month when we had friends over for dinner, and the conversation turned to our work. I mentioned Accountable Care Organizations and got blank stares. The Affordable Care Act of 2010—yes, the one that created Obamacare—also authorized new methods to save money. One of those methods is Accountable Care Organizations, or ACOs, which began in 2012. There are several in and around our city of Chicago. Over ten years later, many consumers are completely unaware of their existence, and most importantly, how ACOs may affect their own health care.

Does it really matter if you, as a health care consumer, are unaware of major trends and

changes in the business of health care? I think it does. Otherwise, as these changes are implemented, you respond to new systems without understanding the implications or knowing how to influence your own situation.

It's time for that to change. Understanding these five major health care movements will get you started:

1. Value-Based Health Care and ACOs are part of a broad movement to improve affordability and quality of health care.

The underlying concept of Value-Based Care is simple: The investment in payments for health care services should produce the best value. Value-Based Care promotes systems to measure quality of services delivered to patients, to reward health care providers (physicians and facilities) for better performance, and to provide incentives for eliminating unnecessary costs.

To understand the trends, get familiar with the terms of Value-Based Care through this previous article, which also will give you more information about the scope of initiatives. The most significant Value-Based Care model is called Accountable Care organizations, or "ACOs" comprising physician practices, either independent or associated with hospitals that work together to identify high quality care and achieve savings.

You may be in an ACO and not realize it, because you haven't changed physicians and are continuing previous care. But if your physician joined an ACO or the health system formed an ACO, that ACO automatically incorporates the patients attributed to its participating physicians. Your membership in a Medicare ACO is based on your past visits to an ACO-participating physician for the majority of your primary care, or if you have no primary physicians or specialists who are participating in the ACO.

Your ACO doesn't reduce your Medicare benefits or change your ability to get care elsewhere. But your ACO could influence your decisions by their referral arrangements or through coordinating services. You can opt out of sharing your data with your ACO, but the only way you can leave it is to change physicians.

If you are in a private insurer ACO plan, your ACO may be aligned with a narrow network coverage under which you might pay more for a non-ACO physician or hospital. That differs by each health plan as well as your employer-based coverage.

As part of helping you navigate your care, your ACO may welcome you to the ACO, to coordinate care, to invite you to ACO programs or education, conduct surveys, or to follow up after admissions or emergency services.

Why should you care about Value-Based Care and ACOs? Because ACOs are actively working to influence how you navigate the system and to optimize your services. If you have frequent encounters with physicians or facilities, they will try to engage you in activities to reduce your health risks. If you are aware of the ACO, you can both benefit from ACO improvements as well as affect the ACO's mission and its initiatives through consumer input.

2. Cost transparency is on the way, but consumers must currently insist on information.

Many consumers are frustrated by not understanding how much planned health care services will cost, or by trying to decipher price information you've been given by providers. Medicare has mandated that hospitals produce accurate pricing information to consumers, but this is new and still at an early stage. You can and should ask for price information before proceeding with "elective" services, including diagnostics, prescription drugs, and therapies.

Health care pricing is extremely complex. What consumers need to know is that most prices are negotiated between the physician group and/or hospital and the individual health plan, or mandated by Medicare/Medicaid. The "charge" is rarely the same as the cost, unless you are paying for the services yourself. Now is the time to take advantage of the trend and ask for the information you need to make decisions.

Consumers should remember also that "coverage" and "cost" are not the same. The difference is huge. If a service is not covered by your insurance, or covered after a steep deductible, you will have to pay most of the cost. If a service is covered but there is still a big cost, you should still know what that is to determine the value of that service. Why? Because you are paying for it either through premiums or in after-insurance costs. Our advice is this: Ask both whether certain services are covered, as well as the total cost and the cost to yourself. And keep asking questions until you are convinced that you have the most complete information.

3. The Informed Patient movement is growing, and along with it the need for consumers to become educated and health-literate.

Health care payers and consumer advocates have long fought for transparency and information

for consumers to make better decisions. The Informed Patient movement is similar to cost transparency, only it is focused on the clinical effectiveness or value of services for improving patient outcomes, including longevity and quality of life. There are various initiatives in this movement to create more awareness of how to navigate better health care, ranging from the federal Agency for Healthcare Research and Quality (AHRQ), which releases various reviews of research on effectiveness of clinical therapies, to the non-profit Informed Patient Institute, and many individual payer and consumer initiatives, including Medicare.

While it's difficult to access evidence-based information on therapies presented in scientific terms or locked behind medical journal paywalls, you can ask physicians to provide information about the effectiveness of various approaches. You should expect to be able to compare the benefits and risks of doing nothing versus doing one or another therapy.

Consumers should also be aware that between 10 to 20 percent of health care services have been identified as "low value," meaning that there are few if any proven clinical benefits. There are many movements to eliminate payment for these services, but also to educate consumers. The American Board of Internal Medicine (ABIM) has done good spadework in educating consumers and physicians about these services through its Choosing Wisely program.

4. Patient health data is growing exponentially, creating benefits and risks to consumers.

The volume and integration of health data is rapidly expanding. Coming from clinical record and imaging systems, insurance claims, scheduling, operating systems, patient wearables and medical devices, and genetics data, health data is fueling artificial intelligence (AI)-driven scientific knowledge advancement.

At the same time, this is the Wild West of data expansion and problem-solving. Patient-originated data is being deployed on a large scale to answer questions that are both clinical and social, but there remain many questions about the validity of the underlying data and their assumptions. Data is never flawless.

So, too, are there issues with data privacy, access to information that could be used, for example, to attach a cost to a consumer's personal decisions that affect health risks. Will your Apple Watch or Fitbit only be used to help you, or will the data connect to your employer and/or insurer? There are cases where the latter is happening now.

Consumers need to know where their health data is being captured, and how to access and control it. Technology is moving towards patient-owned and controlled data, but currently the

“owners” of patient data are health care providers, insurers, and private business.

5. Recognition of health inequities is generating opportunities for change—with continued strong advocacy.

COVID-19 illuminated the disparities in health care for people of color, rural communities, and indigenous Americans. While the medical literature has abounded with data showing these disparities for many years, the pandemic highlighted the severe toll that these inequities create. Likewise, but less emphasized at present, are health care issues faced by women, regardless of origin.

There are fledgling new initiatives with funding to close the gaps in access and coverage. The Medicare program has announced that it is seeking to better measure equity as part of Value-Based Care. But how does any of this matter to you, if you aren’t in one of the groups that may be specifically helped?

Health care is financed on a sliding payment scale; people who have coverage pay more. People who can’t get coverage or treatment aren’t exactly “free” to the system. Instead, their costs may be tallied in a slightly different way. For example, they could end up much sicker and using more costly, higher end resources in the Intensive Care Unit. The cost of that “free” care is shifted onto insurance premiums for people with private insurance. There is no such thing as free—we are all paying for the inefficiencies of health care. So we all have a stake in making it more equitable and effective.

Strong advocacy will be essential to sustain initiatives that address health care disparities. As a social issue, it is a target for political disputes. In the past, there have been many studies of disparities that produced treatises and recommendations but lacked long-lasting solutions.

Being more informed about health care helps health care work better for consumers. It’s complex, mostly because it has been hidden from consumers—and not by subterfuge. Patients are invisible because they purchase health care through a intermediary insurer, and that insurer has been calling the shots. But as a consumer, you don’t need to be either invisible or silent.

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